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Extended residential courses

THE MSD Foundation runs extended residential courses for young general practitioners which are aimed at helping future leaders in the field of postgraduate medical education. The weekly medical press has commented on the 'elitist' nature of the courses, but the Foundation is not the first body to attempt to influence general practice through the medium of a relatively small number of participants attending extended courses. In the early 1970s the Royal College of General Practitioners ran the Nuffield courses (supported by the Nuffield Provincial Hospital Trust) which were influential in the implementation of vocational training for general practice, and in the late 1970s the Scottish Council for Postgraduate Medical Education[1] ran a smaller course aimed at potential regional and associate advisers in Scotland. The Nuffield courses have been well described[2] and their small group methods have subsequently been employed in vocational training throughout the country. Most of the participants of the Nuffield courses have become actively involved in medical education.

What are the benefits of the extended residential course? Meeting tutors and other members of the course over a relatively long time period and focussing attention on personal qualities and skills produces a learning experience which cannot be achieved in the usual forms of continuing education. The small group approach of the Nuffield and the MSD Foundation courses fosters the creation of a bond of trust between participants which enables them to reveal and understand their personal approach to patient care. The main drawback of extended courses is also their chief advantage — the time that course members are away from their practices. It is of interest that the duration of extended courses has decreased from the 30 days of the Nuffield courses, to the 20 days of the extended courses in Scotland and finally to the nine days of the MSD Foundation leadership courses. All the courses require work to be carried out between the short residential sessions.

General practice is an evolving discipline with times of rapid change such as the periods following the Charter of 1965 and the introduction of mandatory vocational training in 1980. We are now once again in a state of flux. This time the issue is not between single handed practice and group practice or whether a general practitioner should undergo special training before being allowed to become a National Health Service principal but rather how to ensure that everyone receives a high quality of service from his or her general practitioner. The College's policy statement *Quality in general practice*[3] and the Government's green paper[4] have made specific proposals for change, designed to improve the quality of care in general practice. It is against this background of change that the MSD Foundation has developed its leadership courses.

One aim of the MSD Foundation courses is to help participants to understand motivation, whether it be of self or of others. In the past the price of leadership has been substantial in terms of its effect on the participant's practice and on his family. Recognizing these costs may allow more realistic roles to be developed for future leaders in general practice which will demand less family sacrifice than was considered normal in the past.

burns in a bomb blast below decks on *Sir Galahad,* and was the only survivor from one of the stern compartments. His face, hands and scalp were especially affected. Following emergency surgery on the hospital ship SS *Uganda,* he was air-lifted back to Britain and underwent a protracted course of plastic surgery and physiotherapy.

He received tremendous support from his family and neighbours in his Welsh village, but broke off his engagement to an English girl. He seemed to feel that local people would judge him by his former self, whereas in a strange place he would be seen as no more than a crippled soldier with bad facial scars. He became moody, irritable and sleepless, frequently quarrelling with his mother, who was his main support. He drank to excess, and it was only when drunk that he could talk of his guilt at surviving. While drunk he revealed that his worst hand burns were sustained as he attempted to push his burning friends to safety but that he had had to leave them eventually.

Discussion

These three young men presented with neurotic disorders which had many features in common, and began six months or more after unusually severe life-threatening stress. They suffered from a mixture of anxiety and depression with some somatic symptoms, frequent flashbacks to their experiences, and guilt at having survived. They also showed difficulty in grieving over lost comrades and their irritability led to family and employment problems. This syndrome corresponds to the American description of delayed post traumatic stress disorder and follows the pattern described by Black in a study of more than 1000 Vietnam war veterans.[4]

Only Case 2 had had previous psychiatric illness, for which he had been successfully treated and passed fit for active service. All three had resorted to alcohol to suppress their symptoms and 'Simon' could only talk of his experience under the influence of alcohol.

That we came across these cases by chance suggests that they may well represent the tip of the iceberg. The comfortable conclusion that the Falklands war had remarkably few psychiatric casualties is not tenable.

One possible contributory factor is the psychological ambience of the armed forces. Preparation for battle involves instillation of a sense of *esprit de corps,* so that the soldier, especially the young recruit, is more concerned at loss of face before his comrades than the prospect of his death or mutilation. However, this sense of group identity leads to a severe sense of bereavement when a soldier loses comrades and the normal resolution of grief through weeping is likely to be discouraged.

In addition, all three of the cases reported here found it impossible to report emotional distress to a service doctor, who is inevitably handicapped by his position in the service hierarchy. We found it surprising that despite the work of army psychiatrists 40 years ago on the importance of front-line diagnosis and treatment of war neuroses (including acute abreaction[5]), there were no Royal Army Medical Corps psychiatrists in the Falklands war.[1]

Heavy use of alcohol is a feature of Army and Navy mess life, and is encouraged by the policy of keeping prices low in the NAAFI. The low price of cigarettes has already been commented on as a factor in the high rate of early cardiovascular disease in the Army.[6] The use of alcohol as a do-it-yourself tranquillizer is likely to perpetuate a grief reaction, and confuse its diagnosis and treatment. This is evident in all three of the cases reported here.

It is important that the delayed psychiatric casualties of the Falklands war are identified so that appropriate help can be offered. It is also important that general practitioners know of the sources of such help, in particular of the Ex-Services Mental Welfare Society, which is able to advise on war pension rights. However, the only way to ascertain the true prevalence of psychiatric casualties of the Falklands war among serving soldiers and their relatives is by epidemiological studies.

In any future conflicts it would appear essential to provide an acute counselling service after these life-threatening experiences, as did Stöfsel[7] in Holland after passengers were held hostage on a train. After their first taste of combat young people need somewhere to express their feelings, somewhere free of the limitations of discipline, free of the constraints on weeping and free of the harmful effects of heavy alcohol use.

Owing to his civilian status, the general practitioner is in a unique position to assess and treat these psychiatric casualties and if necessary refer them for specialist opinion.[8] It is likely that further problems will present for some years to come.

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Fansidar in malaria prophylaxis

Prophylactic advice for visitors to areas endemic for chloroquine-resistant falciparum malaria is already difficult, and the problem has been increased by recent evidence on the frequency of side-effects to Fansidar (pyrimethamine, Roche).

A survey in the USA showed that several deaths due to Stevens-Johnson syndrome, erythema multiforme or toxic-epidermal necrolysis had occurred in those taking Fansidar since the drug became available on the American market in 1982. The fatality rate is estimated to be between 1 in 18 000 and 1 in 26 000, in those receiving Fansidar in the USA. Such a level is unacceptably high for a prophylactic under most circumstances, and has led the USA to suggest the use of chloroquine for short-term visitors even to chloroquine-resistant *P. falciparum* areas, with a curative dose of Fansidar in the pocket, and to leave a wide range of options open for the long-term visitor to such areas.

On the basis of what is known or implied by the information at present available, it would appear advisable not to recommend Fansidar to visitors to areas of chloroquine-resistant *P. falciparum* malaria, where Fansidar or Maloprim was recommended in the past, at least until further information becomes available.

Source: PHLS Communicable Diseases Surveillance Centre. Fansidar in malaria prophylaxis. *Communicable Disease Report* 1985; weekly edition 85/20: 1.

the patient wants but hardly anything of what the patient needs. On the other hand, British general practice may go flirting with a fee-for-item-of-service system just at the time when North America and Australia will be coming more and more to realize the benefits of a pre-paid service.

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Predicting complications in coronary care

The use of the initial electrocardiogram as a predictor of complications was evaluated in 469 patients with suspected acute myocardial infarction. An electrocardiogram was classified as positive if it showed one or more of the following: evidence of infarction, ischaemia, or strain; left ventricular hypertrophy; left bundle-branch block; or paced rhythm. Life-threatening complications were 23 times more likely if the initial electrocardiogram was positive ($P<0.001$). Other complications were 3 to 10 times more likely ($P<0.01$), interventions were 4 to 10 times more likely ($P<0.05$), and death was 17 times more likely ($P<0.001$) in patients with a positive electrocardiogram.

The authors conclude that patients with a negative initial electrocardiogram have a low likelihood of complications and could be admitted to an intermediate care unit instead of a coronary care unit. This would reduce admissions to the coronary care unit by 36% and thereby save considerable hospital costs without compromising patient care.

Source: Brush JE, Brand DA, Acampora D, *et al.* Use of the initial electrocardiogram to predict in-hospital complications of acute myocardial infarction. *N Engl J Med* 1985; **312:** 1137-1141.